DOCUMENT RESUME

ED 197 261 CG 014 910

AUTHOR Lublin, Irwin; Kirkish, Patricia
TITLE An Original Behavior Modification Program for Weight Reduction: Minimal Intervention and Permanent Habit Change.
PUB DATE Apr 78
NOTE 14p.; Paper presented at the Annual Meeting of the Western Psychological Association (58th, San Francisco, CA, April 19-22, 1978).

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Behavior Change; *Behavior Modification; Body Weight; *Change Strategies; Counseling Techniques; *Eating Habits; Females; Individual Development; *Intervention; Motivation; *Obesity; Program Descriptions; Program Evaluation; Psychological Patterns; *Self Help Programs

ABSTRACT

This description of a weight reduction program, based on generalizations derived from eight years of work with overweight persons, discusses the clients' rationalization of overeating behaviors. In this behavior modification program, the client is required to permanently give up one high calorie food and to write down all foods eaten before actual consumption occurs. Methods for giving up foods, substituting low calorie foods, and keeping a food ledger are presented. Program forms, provided in the appendix, are explained in the text. The initial intake interview with the client is described in detail as a strategy for determining the client's behavior motivation and present eating habits. A follow-up evaluation is also discussed, in which 32 of 38 former clients weighed less at the follow-up than at their entry point into the program. (NRB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED197261

AN ORIGINAL BEHAVIOR MODIFICATION PROGRAM FOR WEIGHT REDUCTION: MINIMAL INTERVENTION AND PERMANENT HABIT CHANGE

Irwin Lublin and Patricia Kirkish
California State University, Los Angeles

U S DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Irwin Lublin

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)"

CG 014910

Paper presented at the Annual Meeting of the Western Psychological Association, San Francisco, April 1978.

W.P.A. San Francisco, April 1979

Revised for Behavior Modification X, Los Angeles, Feb. 1979

An Original Behavior Modification Program for Weight Reduction: Minimal Intervention and Permanent Habit Change

Irwin Lublin Patricia Kirkish
California State University, Los Angeles

The program about to be described had its origins in the Summer of 1970, when the senior author and a small group of graduate students met in a weekly seminar to devise behavior modification strategies for weight reduction. Since I had already devised a successful treatment for cigarette addiction based on conditioned aversion, we pursued that avenue of discussion exhaustively. Our suggestions had at least one effect; they made us lose our appetites.

It seemed to me then and I still believe, that it would be possible, by resorting to powerful elicited responses of disgust and nausea, to classically condition generalized aversion to food. However, it hardly seemed advisable or even ethical to substitute anorexia for overweight, especially since anorexia, according to the literature, is an even more difficult problem to deal with than overeating. Although conditioning aversion to certain "problem" foods at first seemed a more acceptable proposal, our first contacts with obese subjects strongly suggested to us that the subjects will evade any solution that is imposed upon them in the nature of aversive conditioning, either by substituting other foods or by counter-conditioning themselves at home, which is easily done. In short, you cannot make people stop overeating, but with help, they can change their eating habits themselves.

We began therefore, by discarding all our preconceptions about overweight and overeating, which was a good idea, because they all turned out to be wrong. Now, eight years later, we have seen about 150 overweight persons in individual treatment, and I have even discarded the greatest and most misleading misconception of all, one which is assumed to be true by virtually all the books and articles on the subject (including Schacter's books and articles) not to mention the multitudes of "diets" which assail us from all sides. I refer to the assumption that overweight people eat a lot, or at least a lot more than normal weight people. After the minute examination of the daily intake of more than 150 overweight men and women over periods of months and even years, it appears to us that although some overweight people eat a great deal, many of them eat very little, and as a class they eat no more than persons of normal weight, some of whom also eat a great deal. We have been unable to find any evidence to the contrary. Apparently this most basic study has never been done. Nevertheless, I must hastily add that of course, every overweight person is ipso facto eating more, at least in terms of calories, than she is burning off. (I will use the pronoun "she" throughout, since about 90% of our clients have been women).

Before we turn to the details of the present program, it may be of some interest to mention some of the generalizations we have arrived at after eight years of intensive work with overweight persons, those which appear to be valid, in distinction to our prior misconceptions, which now appear as ludicrous to us as the psychoanalytic explanation of obesity, which, as most of you know, is that obese persons are trying to make themselves unattractive to the opposite sex, lest oedipal dangers be revived. In that connection it may be of some interest to mention that the most frequent answer we have received to the question -- why does the client

wish to lose weight -- is because she is presently physically unattractive to the opposite sex.

I believe the generalization we have arrived at that is of the most general interest is our answer to the question, why do these people continue to overeat, if they do not wish to gain weight? It is simply this: For most of our clients, eating is either their main physical gratification in life, or their only physical gratification. It should be remembered that many obese persons have either no sex life, or a very unsatisfactory one. Furthermore, we have asked many clients which they would give up if they had to give up either food or sex, and they have almost without exception quickly replied, "Sex." None of them paused to bicker with the terms of the question. They understood what the question meant and we understood what the answer meant. In this way, we arrived at the conclusion that for the most part, we were dealing with food addictions every bit as powerful as drug addiction or alcohol addiction.

The most useful generalization we have arrived at has to do with the mechanism used by almost all overweight persons to lessen the stress occasioned by the fact that their problem, unlike many other problems, is constantly visible, and that they are constantly faced with the conflict of wanting very much to eat certain foods despite considerable social pressure. I refer to the mechanism of rationalization, which is used massively if not exclusively by our overweight clients. The most common form we have encountered is almost universal. It is simply this: Almost all persons who are heavier than they would like to be say to themselves almost every day, "It doesn't matter what I eat today, because tomorrow I'm going on a diet." Evidently they almost all say the same words to themselves, because when we ask them if they do, they admit with embarrassment that they have been saying the same words to themselves every day for years, often for 10, 20, or 30 years. The remarkable thing is that this rationalization never seems to lose its reinforcing power, despite the fact that, as William James observed in 1890, tomorrow never comes. As soon as they say these words or other similar, they feel better. In this way, the rationalizations, which themselves become habits, keep the faulty eating habits going. Another way to put it is that the rationalizations take the pressure off the here and now, which means that the pressure is always off while the person is actually eating.

Among the other rationalizations commonly encountered are these:

1. Although I am eating a lot today, I hardly ate anything yesterday.
2. You can't diet when you eat in a restaurant.
3. Since I am getting all this exercise (jogging, at the gym, playing tennis, etc.) I can eat all I want.
4. If you don't eat much carbohydrate, you can eat all you want.
5. You can't diet on the weekend (or on your vacation).
6. You can't diet when you are a guest at someone's house.
7. I only keep the cookies (etc.) in the house because the children would complain if I didn't have them (but then I eat them).
8. I feel that it's a sin to waste food (so I eat all the leftovers).

It should be evident that since these rationalizations and many more we don't have time to mention (some of which are almost bizarre) support the faulty eating habits, they cannot be accepted by the therapist. For example, in the case of the last one mentioned, the therapist simply asks the overweight client, "Do you mean that if you eat the leftovers they are not wasted?" In the case of the universal rationalization mentioned first, we always ask, "If you are going on a

diet tomorrow, then doesn't it count just as much what you eat today?" Our experience has been that these rationalizations only work so long as people accept them as reasonable.

One last example of rationalization of overeating is very informative in that it accounts for what seems to be strong motivation on the part of prospective clients who yet are unwilling to expend even the smallest effort in the program once they are accepted. We were very puzzled by clients who kept bugging us to get into the program, wrote letters expressing desperation, saying it was a life and death matter, that they would do anything if they could lose weight and so forth. Yet some of these same clients missed all of their first few appointments, could not seem to write down what they ate -- saying it was a lot of trouble -- and many similar signs of very low behavioral motivation. One client, after bugging me every week for about six months, actually said at his intake interview, "I don't know if I can buy a notebook." (Need I add that this client was a complete failure?)

What has this to do with rationalization and the overweight? Simply this: About 20% of our clients are desperate to get into a program but not desperate to lose weight. It is to get their relatives, spouses, friends, etc. off their backs. And to make themselves feel better about continued overeating. They want to be able to say, to themselves as well as others, "See, I am trying to lose weight. Don't give me those funny looks while I am eating." Someone has observed about these persons, "they don't want to lose weight. They want to have lost weight." Needless to add, since we came to understand these 20%, we do not allow them to use our program as an excuse for continued overeating. We simply observe that we will be unable to help them. We also know that they have been in many programs and on many diets before ours and they will be in some other program very quickly after ours.

Description of the Present Program

The program has been evolving since 1970. It appears to be fairly stabilized in its present form. An inspection of the forms in the appendix will give the reader a rough idea of what we are up to.

A very brief description of the program involves what we ask the client to do, which is only two things: 1. Select one food item (e.g. mayonnaise) or category (e.g. candy) that she eats frequently and that is high in calories that she can give up fairly easily - but permanently. 2. Write down everything she eats before she eats it, in a food ledger which she always has with her.

Our clients are usually astonished at how little we ask of them. It appears to me that the main reason the respectable programs fail (I will not even discuss the many quacks in this field) and I speak here of such well-meaning, rationally designed programs as Weight Watchers and the Ferster-Stuart program with its many imitators, is that although they make sense logically, they make no sense psychologically. These two and others, ask the overweight person to follow so many rules that they seem to demand changes in virtually all of the person's well-established food selection and eating habits. Not only is it unrealistic to expect anyone to change all of these overlearned habits permanently, but it is unrealistic to expect many people to follow so many rules to start with.

Simple examples are telling people that they must eat fish four times a week, that they can only eat in one place (such as the kitchen), that they can not eat any of their favorite foods, that they must prepare one meal for themselves and another for the family (with no prepared foods permitted in the house).

About a third of our clients have already foundered on one of the four rules just listed. And then they say, "Since I broke the one rule, I figured I might as well break all of them." A rationalization to be sure, but one that is almost inevitable given too many rules. Many of our clients ate one or more meals per day at school or work and could not eat at the kitchen table. Many of them hated fish and did not see why they had to eat it at all, as we did not. A minimal intervention strategy seemed much more likely to succeed both initially and ultimately. It is certainly worth noting that if the client reduces her caloric intake, even by changing a single food habit, she will lose weight regularly. And so they do.

Our clients have typically given up one food, such as ice cream, Seven-Up, mayonnaise, etc. And have typically lost at least a pound a week from that item alone. It happens that the clients who gave up the three items just mentioned lost 4 pounds a week, but they were eating respectively a quart of ice cream, 10 Seven-Ups, and a half-a-loaf of bread spread with mayonnaise every day. On the other hand, these very clients, after a month or less, reported that their cravings for those foods had disappeared. Which is why it is better to give up one food completely than to eat less of many foods. As long as the person eats the food even occasionally when she craves it, the craving, which is almost certainly a classically conditioned response, continues full strength. But if she stops eating the food item completely, despite the craving, the craving may be expected to extinguish. In our experience, 9 out of 10 persons follow the predicted extinction curve. In about a month or so, cravings are down to one a day or less, and frequently disappear entirely. The longer they go without that food the less they want it.

On the other hand, let us assume, to follow the example through, that she volunteers to give up pie. We have learned to ask, "How about cake and cookies." A few food items do run in categories. Agreeing to give up one kind of candy, one

kind of cake, one kind of ice-cream, will usually result in substitution. But most foods do not run to categories in our experience. Persons who have agreed to give up hamburgers have not substituted veal chops or even steak. Persons who have given up ice-cream have not substituted whipped-cream, and so forth. On the other hand, when ice-cream is volunteered, we always ask, "How about ice-milk, sherbet, and frozen yogurt?" There are many such rules of thumb which we cannot cover, but the close observer of behavior with an open mind will inevitably acquire them with experience.

From Item #11 on our Intake Outline it will be noticed that we develop a list of foods that the person likes that are low in calories. They are encouraged to substitute one of these whenever they feel like eating something, which as most of you know is not the same as whenever they are hungry. Another generalization that seems safe at this time is that most overeating is not done while in a state of hunger, but in some emotional state, such as loneliness, anxiety, boredom, etc. In this way, many of our clients have gotten "hooked" on a food that is harmless to them, such as cantaloupe, baked potatoes, sugar-free soda pop, or salads. They are encouraged to eat whenever they feel like it and never to feel deprived. Starvation and crash-diet regimens seem rationally as well as empirically to be doomed to failure, since they actually are designed for short-term weight loss, which is worse then none.

A few words are in order about the only other thing we require the client to do -- again it sounds simpler than it is. If you look at the form headed "Food Consumption Ledger", you will see that she is asked to make an entry each time before she eats, whether a meal or a snack. She is asked to indicate the size of portion, how many calories are in it, and to rate both her hunger and her degree of preference for the food she is about to eat from 0-5.

It is our experience that this intervention alone (although the range is quite wide) causes the average client to lose about a pound a week, which translates roughly into a reduction of 3500 calories in the week, or 500 calories a day. It is evident that programs that require the client to keep a food ledger for a week or two "to get a baseline" will never get a baseline. Feedback from our clients makes it clear what is happening. First of all, the prior-entry method means that both automatic and semi-automatic eating disappear. The client's eating becomes fully conscious. Secondly, the client is forced to think twice about each act of eating, with full knowledge of its caloric significance and whether she is hungry or not. Thirdly, many entries will have to be explained to the therapist, who will be hard to explain to.

A single example will suffice: The client enters one piece of pie a' la mode, 650 calories, 0, 0. That means she was not only not hungry, but she doesn't like or didn't want the pie. She anticipates that her therapist will ask why she ate it and she will say that when your hostess offers you something, you have to eat it; and then the therapist will ask, "Why?" Result: She runs a line through the entry, and tells the hostess, "It looks delicious, but I am trying hard to lose weight." The hostess says "I wish I had your will-power," and the therapist congratulates her for following not only the letter but the spirit of the program. She also loses 3 ounces by that one act. A year of only that sort of change once a week would result in a loss of 156 ounces or 10 pounds. If the ledger causes 10 changes of that importance in her behavior during a week, she will lose 100 pounds in the year. It is worth adding that we are assuming she gave up not one food completely.

It only remains to discuss the Intake, which is certainly the most important interview with the client, and some actual data concerning our long-term experience of success. The forms other than the Intake are rather self-explanatory. The medical release is used so that we do not have to concern ourselves with our client's medical problems, whether associated with overweight or not. In seven years, only one physician has refused to sign the statement "I have no objection to this patient participating in the program as described." Of course, that may be because it is always medically beneficial for overweight patients to lose weight.

The Intake Interview takes about two hours. The Outline in the appendix is only a guide. The therapist does not read off the items verbatim, nor is it necessary to follow the given order. We have already commented on Item #2. It was designed to assess the client's motivation verbally. Unfortunately it provides little positive information, although sometimes some negative information. If we ask, "Why do you wish to lose weight?" and the client answers that her doctor warned her that if she didn't lose weight, she might develop diabetes, or heart trouble, or arthritis, etc., she is usually indicating that her doctor is more concerned about her weight than she is. Not surprisingly, when we ask, are you concerned about that?, the client usually says, "Frankly no. I can't get concerned about something that might happen 5 years from now."

We have found that the client's actual behavior during the first week, in which she is seen three times, provides a good idea of her behavioral motivation, which is a good predictor of ultimate success. We are constructing a behavioral motivation scale, which will assign weights to such behaviors as: appearing at all 3 interviews, appearing on time, buying a notebook, starting it the day of the intake, entering everything eaten in the ledger, making all entries before eating, making complete entries, making legible entries, calling ahead if emergency prevented client from appearing, and so forth.

We have found that clients who are good about their appointments and ledgers the first week are usually good every week, that they lose weight regularly, and that they keep it off. On the other hand, a bad first week is almost inevitably a predictor of failure. If we dropped everyone with low behavioral motivation after the first week, there appears to be little doubt that we could achieve over 50% long-term success, which as most of you know is unheard of in this field.

It appears at this point that it is at least as hard to eliminate overeating as it is to eliminate alcoholism or drug addiction, both of which are very hard indeed. For the behavior modifier, it should not be surprising that food addictions are much harder to eliminate, since we can wipe out alcohol or other single substance abuse by conditioning aversion, whereas we hardly wish to wipe out eating, even though all food has calories.

The most important single items in the Intake Interview are probably #7 and #8. These are the portion of the Intake in which we assess the person's present eating habits in great detail. From these, we arrive at some formulation of what is generally the behavior modifier's first question: What are the problem behaviors?

Although the basic question we want answered is "What do you eat in a typical day?" you will note that we ask that question in several different forms. That is because the overeater, especially the person who actually eats a great deal, does not give up her guilty secrets without urging and prodding. We say, "tell me what

you ate yesterday", in case the person gave us a light day instead of a typical day to #7, in which case she usually says "Oh, yesterday was a bad day!" We ask "What are your favorite foods" in case the client has omitted any or all of them from her typical day. If she says, "I don't have a typical day," we say "Give me a typical bad day, and a typical good day." If she says, "I eat differently on school days," we say "give me a typical school day," and a typical day when you eat at home." If she says, "I eat differently on the weekend," we say, "give me a typical Saturday or Sunday" After much questioning our bulldog persistence pays off. We believe we get pretty close to the baseline eating behavior. Therefore, when we ask Question #9, the answer is usually forthcoming as well as obvious.

Occasionally, the client, who knows her behavioral categories better than we do, gives a better response category than we would have selected, since we tend to focus on food selection. Thus one client said, "How about eating in fast-food restaurants, like McDonald's, Jack-in-the-Box, Colonel Sanders, In-and-Out Burgers, Pizza Hut, and Taco Bell." In that case, the client made a drastic change in her caloric intake, but the eating habit involved was to her a single category which was easy to give up. It is best never to second-guess the client about what would be easiest to give up permanently. They know. They also know what they could never give up permanently. It is often an item that Weight Watchers or their family physician made them give up. The day they reached their goal they gorged themselves on that item.

Most of our clients, including those who ultimately lost 50, 100 or 200 pounds, have never stopped eating some high calorie foods which they cherished. Why should they? Why should we tell them what they cannot eat? In many programs, especially medical programs, the doctor goes on eating what he forbids the patient to eat. As our clients always tell us, it's not fair.

RESULTS

Reference to the Appendix will reveal that we have apparently succeeded with our program and that our reasoning spelled out above has been confirmed by the empirical facts. We drew a sample consisting of all the people who had been out of the program at least six months whom we could both locate and get in for a "brief interview" (actually we wanted to weigh them). As of April 1978, that consisted of 38 persons. We included both drop-outs and failures, so our results are probably not biased for success.

Of the 38, 10 were males and 28 females. They had been out of the program for a mean of 30 months -- the range was 6 months to 6 years. Four persons weighed more (2-5 pounds) on follow-up than upon entry to the program. Two persons weighed the same. That leaves 32 of 38 persons who weighed less on follow-up than upon entry -- 84% successful. As an aggregate, they weighed an average of 36 pounds less after treatment and 29 pounds less upon follow-up (includes failures).

CALIFORNIA STATE COLLEGE, LOS ANGELES

WEIGHT REDUCTION CLINIC -- Irwin Lublin, Ph.D., Director

Date_____ Name_____ Phone(day)_____

Phone(evening)_____ Address_____

Name, address, and phone of someone who will always know your current address:

Weight (dressed)_____ On what scale?_____ Exact?_____

Height without shoes_____ Age_____

How many pounds overweight do you consider yourself?_____

How long have you been this overweight?_____ How long overweight?_____

What members of your immediate family are overweight? (include spouse)

Do you have any health problems associated with overweight? Elaborate:

Do you have a physician whom you see regularly? Supply name, address, and phone if you know it:

When was the last time you had a complete physical examination?

Give the name of a person who is familiar with your daily habits and sees you regularly at meals. (spouse, parent, roommate, etc.):

Would this person be willing to cooperate in helping you to lose weight?

Summarize how much exercise and in what form you get in an average week:

What is your occupation?_____ Outside activities?_____

Please summarize your previous attempts to lose weight. Give details of names of programs or physicians, weight lost, weight regained, period of time involved, how long ago, etc. (continue on other side):

List present clothing sizes (suit or dress, collar, belt, bra, hips):

CALIFORNIA STATE UNIVERSITY • LOS ANGELES

5151 STATE UNIVERSITY DRIVE LOS ANGELES, CALIFORNIA 90032
Department of Psychology

Dear Dr.

Your name has been given to us by a patient of yours, who has applied to be a participant in a Weight Reduction Program we have instituted in the Psychology Clinic here. Please read the statement below and date and sign it if you have no objection to your patient participating in the Program as described. Please note that the program will be based entirely on change in eating habits, and note any qualifications you may have based on medical problems of your patient.

Yours sincerely,

Irwin Lublin, Ph.D.
Director, Weight Reduction Program
Licensed Psychologist

I know of no medical reason why my patient named above should not participate in the Cal State, L.A. Weight Reduction Program. I understand that no drugs, electric shocks, or other physical interventions will be administered or advised, and that the Program will be based entirely on changes in eating habits. I also understand that the patient will not be advised to undertake any "starvation diets" or rapid weight loss regimens (more than 5 pounds a week) unless under competent medical supervision. Special Dietary Requirements of this patient, if any, are noted below.

Date_____ Signature_____

Office Address_____

Special Dietary Requirements of this patient (if any):

WEIGHT REDUCTION PROJECT -- OUTLINE FOR INTAKE INTERVIEW (Attach notes):

Date _____ Names of intake interviewers _____

1. Has client filled out a questionnaire? If not, do it now.

2. Explore motivation: Why do you wish to lose weight? Why shouldn't you remain at your present weight? Whatever reason is given. Is that very important to you, etc.

3. Ideally, how much would you like to weigh? And what size would you like to be? (suit or dress)

4. About how much weight would you like to try losing per week? If you only lost 1 pound in a given week, would you be discouraged?

5. Do you think that you can make a permanent change in your food selection or eating habits or both? (subject must understand that WRP is not interested in temporary weight loss)

6. Weigh S on standard scale. E of same sex will ask permission to take S's measurements and record them: neck, chest, stomach, waist, upper arms, lower arms (at widest point), hips (around buttocks), calves, and thighs, (use judgment concerning privacy for thighs measurement).

7. Would you please describe your food intake in a typical day from the time you get up until the time you go to sleep. Include everything you put in your mouth. What are your favorite foods?

8. Please list everything you ate yesterday and under what circumstances: (snacking, private eating, social eating, TV eating, restaurants, parties, etc.)

9. Could you mention a fattening item in your diet that you could give up fairly easily, an item that you eat often? Could you mention two more fattening items that you eat often that you could give up relatively easily?

10. Do you keep snack food in your house? What? Why? If you removed ready to eat snack foods (candy, cookies, pretzels, potato chips, pastry, etc.) from your house, would the rest of your family complain? Would you eat these things if they were not in your house? How about ice-cream, beer, whiskey? Soft drinks?

11. Could you name some low calorie items that you like to eat that you would enjoy snacking on if they were always available? How about low calorie soft drinks, salad dressing?

12. Are you familiar with the caloric values of most foods? (Try a few examples). Get a small booklet that you can carry with you.

BETWEEN APPOINTMENTS

Keep a detailed ledger of everything you eat or drink. Before you eat any item or meal, enter the date and time, other activity at time, food item(s), estimated calories, and rate from 0 to 5 how hungry you are and how much you prefer that particular food item. Explain ledger form.

FOOD CONSUMPTION LEDGER for WEIGHT REDUCTION PROGRAM

Note: Entry must be made before eating meal or snack in question.

Date	Time	Activity	Food and portion	Calories	A Rating B	
					Hunger	Preference

Explanation:

Date: Enter date just once each day. After-midnight food with previous day.

Time: For meal eating, give time begun. For snacks, drinks, etc., give time of each.

Activity: If you eat the item alone in the kitchen, write "kitchen." If eating in a restaurant, write name of restaurant. In most other cases, there will be some activity to record, e.g., TV, newspaper, talking to family, lunch at work, school cafeteria, etc.

Food: Include description of each type of food to be eaten, and estimate of size of portion in ounces, cups, tablespoonsful, etc.

Calories: An estimate will do. Your therapist will check to see if your estimates are close. Add up this column at end of day.

Rating: Rate each snack and each item in meal. Make two ratings for each item.

A) Hunger: Rate from 0 (not hungry) to 5 (very hungry). 1 means slight hunger. 2 means less hungry than usual. 3 means an average degree of hunger. 4 means rather hungry.

B) Food Preference: Rate from 0 (no preference whatever) to 5 (strong craving for this particular food, nothing else would do). 1 means slight preference for this but could easily substitute. 2 means you prefer this food but others would do. 3 means you experience a craving for this food, but might be able to substitute. 4 means you might be able to substitute something else, but only with difficulty. Note that 0 also means you could easily omit this food and 5 means that you would really feel deprived if you omitted this food, or even postponed it.

Important: You must make your entry before each occasion on which you plan to eat something. If after making the entry you change your mind and decide not to eat or to substitute something else, draw a line through the item you did not consume and add any item you may have decided to substitute.

BRING YOUR LEDGER WITH YOU TO EACH APPOINTMENT. IF YOU CANNOT COME FOR SOME GOOD REASON, YOU MUST CALL PRIOR TO THE APPOINTMENT, PREFERABLY AT LEAST ONE DAY BEFORE. CALL THE ASSOCIATED CLINICS, 224-3623.

FOLLOW-UP RESULTS AT 30 MONTHS (AVERAGE)

B.M. X
LUBLIN

CLIENT	SEX	WEIGHT AT TIME OF INTAKE	TERMIN.	F/U	F/U (MOS.)	INIT.LOSS	NET LOSS
MR	M	225	160	175	12	65	50
ER	M	372	290	225	24	82	147
DM	M	175	161	171	24	14	4
JH	M	295	230	219	22	65	76
RN	M	248	255	250	60	(7)	(2)
DB	M	250	176	188	24	74	62
WM	M	200	161	161	12	39	39
SR	M	164	135	146	17	29	18
AL	M	278	213	229	12	65	49
GW	M	250	230	250	12	20	0
LL	F	223	203	233	48	20	(10)
JC	F	251	192	225	60	59	26
PM	F	212	134	159	24	78	53
KG	F	191	163	163	12	28	28
CG	F	218	168	170	24	50	48
SG	F	144	140	147	24	4	(3)
CA	F	155	152	155	12	3	0
JW	F	137	128	127	10	9	10
NO	F	167	156	152	15	11	15
DH	F	228	180	178	6	48	50
JR	F	435	271	310	36	164	125
PK	F	152	121	122	48	31	30
JL	F	126	111	111	48	15	15
EP	F	150	131	133	5	19	17
CG	F	235	168	160	36	67	75
JH	F	180	180	179	36	0	1
CM	F	151	145	148	72	6	3
SK	F	190	165	175	72	25	15
JT	F	175	172	180	60	3	(5)
AY	F	204	170	175	60	34	29
CB	F	263	224	267	60	39	(4)
JC	F	219	183	204	12	36	15
MC	F	320	308	308	12	12	12
JP	F	320	277	295	60	43	25
KM	F	204	176	202	12	28	2
WR	F	236	235	217	12	1	19
MW	F	140	125	125	24	15	15
GL	F	148	145	140	60	3	8

SUMMARY DATA

N: 38
M 10
F 28

Means: 30 36 29